		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023317

Facility Name: Eldercare of Alton

Address: 3525 Wickenhauser (Number) Alton (City) 62002 (Zip Code)

County: Madison

Telephone Number: (618) 465-8887 **Fax #** (618) 465-1811

IDPA ID Number: 37-1024089002

Date of Initial License for Current Owners: 04/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Wayne Franklin **Telephone Number:** (618) 624-2157

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) See Accountants Compilation Report (Date)
(Print Name and Title) J. Wayne Franklin, Senior Manager
(Firm Name & Address) Blue & Company, LLC
125 Springfield Court, Suite #1, O'Fallon, IL 62269
(Telephone) (618) 624-2157 Fax # (618) 624-2159

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	138	Skilled (SNF)	138	50,508	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	187	TOTALS	187	68,442	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,307	935	2,131	9,373	8
9	SNF/PED					9
10	ICF	44,556	6,608		51,164	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,863	7,543	2,131	60,537	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.45%

D. How many bed-hold days during this year were paid by Public Aid? 27 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 2,131

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	189,122	23,208	15,241	227,571		227,571		227,571			1
2	Food Purchase		274,736		274,736		274,736		274,736			2
3	Housekeeping	198,545	21,085		219,630		219,630		219,630			3
4	Laundry	89,293	12,038	19,754	121,085		121,085		121,085			4
5	Heat and Other Utilities			104,562	104,562		104,562	2,281	106,843			5
6	Maintenance	50,042	21,957	41,043	113,042		113,042	3,474	116,516			6
7	Other (specify):*											7
8	**TOTAL General Services**	527,002	353,024	180,600	1,060,626		1,060,626	5,755	1,066,381			8
	B. Health Care and Programs											
9	Medical Director			17,800	17,800		17,800		17,800			9
10	Nursing and Medical Records	1,542,313	117,348	254,825	1,914,486	(110,522)	1,803,964		1,803,964			10
10a	Therapy	55,616	1,123	146,167	202,906	(34,825)	168,081		168,081			10a
11	Activities	59,960	6,223		66,183		66,183	(825)	65,358			11
12	Social Services	53,678	125	9,609	63,412		63,412		63,412			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,711,567	124,819	428,401	2,264,787	(145,347)	2,119,440	(825)	2,118,615			16
	C. General Administration											
17	Administrative	139,783		75,455	215,238		215,238	(75,455)	139,783			17
18	Directors Fees											18
19	Professional Services			9,770	9,770		9,770	6,635	16,405			19
20	Dues, Fees, Subscriptions & Promotions			47,587	47,587	(508)	47,079	(20,875)	26,204			20
21	Clerical & General Office Expenses	245,038	16,286	37,849	299,173	508	299,681	12,106	311,787			21
22	Employee Benefits & Payroll Taxes			347,470	347,470		347,470	20,370	367,840			22
23	Inservice Training & Education			954	954		954		954			23
24	Travel and Seminar			9,522	9,522		9,522	2,508	12,030			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,430	26,430		26,430	222	26,652			26
27	Other (specify):*											27
28	**TOTAL General Administration**	384,821	16,286	555,037	956,144		956,144	(54,489)	901,655			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,623,390	494,129	1,164,038	4,281,557	(145,347)	4,136,210	(49,559)	4,086,651			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eldercare of Alton #0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			101,788	101,788		101,788	3,160	104,948			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			79,645	79,645		79,645		79,645			33
34	Rent-Facility & Grounds			508,298	508,298		508,298	7,272	515,570			34
35	Rent-Equipment & Vehicles			372	372		372	4,689	5,061			35
36	Other (specify):*											36
37	**TOTAL Ownership**			690,103	690,103		690,103	15,121	705,224			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					145,347	145,347		145,347			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,664	102,664		102,664		102,664			42
43	Other (specify):* See Attached			16,683	16,683		16,683	(2,752)	13,931			43
44	**TOTAL Special Cost Centers**			119,347	119,347	145,347	264,694	(2,752)	261,942			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,623,390	494,129	1,973,488	5,091,007		5,091,007	(37,190)	5,053,817			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Detail for line 43:

Vending Machine costs	$13,931
Sales Tax	$2,752
Total	**$16,683**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,752)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(388)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,487)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(11,542)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (26,169)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(11,021)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (11,021)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (37,190)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	Therapist	X		34,825	10a-3	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		3,217	10-2	42
43	Prescription Drugs	X		41,701	10-2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule Supplies	X		65,604	10-2	45
46	Other-Attach Schedule Off. Supplies	X		508	20	46
47	TOTAL (C): (sum of lines 38-46)			$ 145,855		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Eldercare of Alton

ID# 0023317

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chamber of Commerce	$ (627)	20	1
2	Miscellaneous Income	(944)	21	2
3	Barber & Beauty Income	(825)	11	3
4	Lobbying Fees	(2,565)	20	4
5	Public Relations	(6,351)	20	5
6	Out of State Travel (Home Office Proration)	(230)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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89				89
90	**Total**	(11,542)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,281	0	0	0	0	0	0	0	0	2,281	5
6	Maintenance	0	0	3,474	0	0	0	0	0	0	0	0	3,474	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	5,755	0	0	0	0	0	0	0	0	5,755	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(825)	0	0	0	0	0	0	0	0	0	0	(825)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(825)	0	0	0	0	0	0	0	0	0	0	(825)	16
	C. General Administration													
17	Administrative	0	(156,357)	80,902	0	0	0	0	0	0	0	0	(75,455)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,635	0	0	0	0	0	0	0	0	6,635	19
20	Fees, Subscriptions & Promotions	(21,418)	0	543	0	0	0	0	0	0	0	0	(20,875)	20
21	Clerical & General Office Expenses	(944)	(101,037)	114,087	0	0	0	0	0	0	0	0	12,106	21
22	Employee Benefits & Payroll Taxes	0	0	20,370	0	0	0	0	0	0	0	0	20,370	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(230)	0	2,738	0	0	0	0	0	0	0	0	2,508	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	222	0	0	0	0	0	0	0	0	222	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,592)	(257,394)	225,497	0	0	0	0	0	0	0	0	(54,489)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,417)	(257,394)	231,252	0	0	0	0	0	0	0	0	(49,559)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eldercare of Alton # 0023317 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	3,160	0	0	0	0	0	0	0	0	3,160	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	7,272	0	0	0	0	0	0	0	0	7,272	34
35	Rent-Equipment & Vehicles	0	0	4,689	0	0	0	0	0	0	0	0	4,689	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	15,121	0	0	0	0	0	0	0	0	15,121	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,752)	0	0	0	0	0	0	0	0	0	0	(2,752)	43
44	**TOTAL Special Cost Centers**	(2,752)	0	0	0	0	0	0	0	0	0	0	(2,752)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,169)	(257,394)	246,373	0	0	0	0	0	0	0	0	(37,190)	45

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	30	Calvin Johnson Care Center	Belleville	Eldercare, Inc.	Belleville	Nurs. Home Mgmt
	50	Columbia Convalescent Center	Columbia			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-1	Home Office Prorate	$ 80,902	Eldercare, Inc.	0.00%	$	$ (80,902)	1
2	V	21-1	Home Office Prorate	101,037	Eldercare, Inc.	0.00%	246,373	145,336	2
3	V	17-3	Home Office Prorate	75,455	Eldercare, Inc.	0.00%		(75,455)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 257,394			$ 246,373	$ * (11,021)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat & Other Utilitties	$	Eldercare, Inc.		$ 2,281	$ 2,281	15
16	V	6	Maintenance		Eldercare, Inc.		3,474	3,474	16
17	V	17	Administrative		Eldercare, Inc.		80,902	80,902	17
18	V	19	Professional Fees		Eldercare, Inc.		6,635	6,635	18
19	V	20	Dues, Fees, Subs, & Promotions		Eldercare, Inc.		543	543	19
20	V	21	Clerical & General Office Exp.		Eldercare, Inc.		114,087	114,087	20
21	V	22	Employee Benefits		Eldercare, Inc.		20,370	20,370	21
22	V	24	Travel & Seminar		Eldercare, Inc.		2,170	2,170	22
23	V	26	Insurance - Prop, Liab		Eldercare, Inc.		222	222	23
24	V	30	Depreciation		Eldercare, Inc.		3,160	3,160	24
25	V	34	Rent - Facility & Grounds		Eldercare, Inc.		7,272	7,272	25
26	V	35	Rent - Equipment & Vehicles		Eldercare, Inc.		4,689	4,689	26
27	V	24	Travel - Out of State		Eldercare, Inc.		568	568	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 246,373	$ * 246,373	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Executive Adm.	30.00	261,748	17	0.34	Salary	$ 80,902	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 80,902		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Other Compensation Detail:

Steve Wolf:

Columbia Care center	$171,772
Calvin Johnson Care Center	$89,976
Total	**$261,748**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Eldercare, Inc.
Street Address: 2620 W. Boulevard
City / State / Zip Code: Belleville, IL 62221-7208
Phone Number: (618) 234-2273
Fax Number: (618) 234-7777

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Direct Cost	10,749,136		$ 4,818	$	5,089,170	$ 2,281	1
2	6	Maintenance	Direct Cost	10,749,136		7,338		5,089,170	3,474	2
3	17	Officer Salary	Direct Cost	10,749,136		170,878	170,878	5,089,170	80,902	3
4	19	Legal & Accting	Direct Cost	10,749,136		14,014		5,089,170	6,635	4
5	20	Dues & Licenses	Direct Cost	10,749,136		1,148		5,089,170	544	5
6	21	Clerical Salary	Direct Cost	10,749,136		213,407	213,407	5,089,170	101,037	6
7	21	Admin	Direct Cost	10,749,136		27,559		5,089,170	13,048	7
8	22	Payroll Taxes	Direct Cost	10,749,136		26,627		5,089,170	12,607	8
9	22	Employee Benefits	Direct Cost	10,749,136		16,399		5,089,170	7,764	9
10	24	Travel	Direct Cost	10,749,136		5,298		5,089,170	2,508	10
11	26	Insurance	Direct Cost	10,749,136		468		5,089,170	222	11
12	30	Depreciation	Direct Cost	10,749,136		6,675		5,089,170	3,160	12
13	34	Building Lease	Direct Cost	10,749,136		15,360		5,089,170	7,272	13
14	35	Equipment Lease	Direct Cost	10,749,136		9,904		5,089,170	4,689	14
15	24	Travel - Out of State	Direct Cost	10,749,136		485		5,089,170	230	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 520,378	$ 384,285		$ 246,373	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2				N/A								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	81,720	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	80,281	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,439)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	81,084	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	79,645	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	76,374	8
	1996	80,703	9
	1997	84,532	10
	1998	80,120	11
	1999	80,281	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,621 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	N/A				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1982	2,080		10			2,080	9
10	Improvements			1983	3,330		10			3,330	10
11	Landscape			1984	1,308		10			1,308	11
12	Improvements			1985	3,728		7			3,728	12
13	Improvements			1985	10,578	529	20	529		8,198	13
14	Improvements			1986	5,506		10			5,506	14
15	Heat Runge			1988	1,190		10			1,190	15
16	Door Alarm			1991	8,986	449	20	449		4,380	16
17	Nurse Station Remod.			1991	60,801	4,053	15	4,053		38,508	17
18	Carpet			1991	1,482		5			1,482	18
19	Asphalt Sealer			1992	2,900	242	12	242		2,273	19
20	Remodeling			1992	77,249	5,150	15	5,150		43,774	20
21	Roof & Remodeling			1993	68,700	4,580	15	4,580		33,205	21
22	Remodel Hall & Offices			1994	20,445	1,363	15	1,363		9,465	22
23	Concrete			1994	1,677	112	15	112		699	23
24	Roof Repairs & Asphalt			1995	2,150	180	12	180		985	24
25	Waste Line Renovations			1996	15,112	756	20	756		3,400	25
26	New Therapy Room			1996	3,782	252	15	252		1,198	26
27	Awnings			1996	12,500	1,250	10	1,250		5,625	27
28	Sidewalks & Parking Lot Seal			1996	8,930	738	5-15	738		3,268	28
29	Landscape			1996	7,436	744	10	744		3,160	29
30	Carpet			1997	1,950	390	5	390		1,268	30
31	Concrete Walls & Signs			1997	14,479	965	15	965		3,379	31
32	Hall Renovations			1998	3,516	352	10	352		879	32
33	Laundry Boiler			1998	1,241	83	15	83		248	33
34	Parking Lot			1998	14,062	1,172	12	1,172		2,930	34
35	Landscaping			1998	1,383	138	10	138		415	35
36	TOTAL (lines 4 thru 35)				$ 356,501	$ 23,498		$ 23,498	$	$ 185,881	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Drywall, Wall Carpet, Stained Glass Door, Lighting-Chapel			1999	20,560	2,056	10	2,056		2,570	9
10	Tubesheets & Copper Tubes in Water Heater			1999	6,904	986	7	986		1,480	10
11	Drywall, Wall Carpet, Electric Work, and Flooring			2000	23,534	1,177	10	1,177		1,177	11
12	Duro-Last Roofing System			2000	165,440	4,136	10	4,136		4,136	12
13	Roof Top HVAC Unit & 2 HVAC/Heat Unit - DR & Kitchen			2000	60,000	1,875	8	1,875		1,875	13
14	Fountain, Brick & Keystone Install, Bush Removal			2000	1,178	59	10	59		59	14
15	Roof Repair (Asset Replaced in Mid-Year)			1990		2,387		2,387			15
16	Roof Repair (Asset Replaced in Mid-Year)			1993		4,132		4,132			16
17	Roof Repair (Asset Replaced in Mid-Year)			1995		299		299			17
18	Loss on Removal of Assets					10,714		10,714			18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 277,616	$ 27,821		$ 27,821	$	$ 11,297	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 455,339	$ 45,162	$ 45,162	$	5-15	$ 173,915	37
38	Current Year Purchases	49,706	3,689	3,689		5-15	3,689	38
39	Fully Depreciated Assets	71,784				FD	71,784	39
40	Home Office Allocation		3,158	3,158				40
41	TOTALS	$ 576,829	$ 52,009	$ 52,009	$		$ 249,388	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport.	1985 Van	1985	$ 10,041	$	$	$	FD	$ 10,041	42
43	Patient Transport.	1991 Bus	1991	39,855					39,855	43
44	Loss on Sale of Assets				1,620	1,620				44
45										45
46	TOTALS			$ 49,896	$ 1,620	$ 1,620	$		$ 49,896	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,260,842	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 104,948	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 104,948	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 496,462	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Vending Machine	$ 4,584	$	$ 4,584	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 4,584	$	$ 4,584	57

G. Construction-in-Progress

	Description	Cost	
58	N/A	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Homes, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1971	187	4/1/77	$ 508,298	20	20	3
4	Additions							4
5								5
6								6
7	TOTAL		187		$ 508,298 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning 04/01/97
Ending 04/01/02

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 372 Description: Office Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	273	$	17,085	$	273	$ 17,085	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		87		6,307		87	6,307	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a-3	hrs		146		11,433		146	11,433	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	10-2	# of prescrpts					41,701		41,701	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Medical Supplies Other (specify): Lab, X-Ray, & Ambula	10-2 10-2						65,604 3,217		65,604 3,217	13
14	TOTAL			$	506	$	34,825	$ 110,522	506	$ 145,347	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 284,979	$	1
2	Cash-Patient Deposits	22,703		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,307,462		3
4	Supply Inventory (priced at)	27,184		4
5	Short-Term Investments	77,025		5
6	Prepaid Insurance	51,365		6
7	Other Prepaid Expenses	39,810		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,810,528	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	634,118		15
16	Equipment, at Historical Cost	626,725		16
17	Accumulated Depreciation (book methods)	(496,242)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 764,601	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,575,129	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 196,461	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,703		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,740		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,621		31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,084		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany Payable	(922,862)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (501,253)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (501,253)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,076,382	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,575,129	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,783,974	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,783,974	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	292,408	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 292,408	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,076,382	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,017,847	1
2	Discounts and Allowances for all Levels	(136,924)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,880,923	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	243,049	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 243,049	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	825	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,147	17
18	Sale of Supplies to Non-Patients	131,207	18
19	Laboratory	11,072	19
20	Radiology and X-Ray	3,146	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 223,397	23
	D. Non-Operating Revenue		
24	Contributions	321	24
25	Interest and Other Investment Income***	10,912	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,233	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	944	28
28a	Vending Machine Income	23,869	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,813	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,383,415	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,060,626	31
32	Health Care	2,264,787	32
33	General Administration	956,144	33
	B. Capital Expense		
34	Ownership	690,103	34
	C. Ancillary Expense		
35	Special Cost Centers	16,683	35
36	Provider Participation Fee	102,664	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,091,007	40
41	**Income before Income Taxes (line 30 minus line 40)****	292,408	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 292,408	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. Return on Extension**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,422	2,080	$ 43,000	$ 20.67	1
2	Assistant Director of Nursing	2,300	2,080	36,058	17.34	2
3	Registered Nurses	14,685	14,915	242,680	16.27	3
4	Licensed Practical Nurses	21,729	23,271	289,958	12.46	4
5	Nurse Aides & Orderlies	88,428	93,733	820,837	8.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,172	6,635	55,616	8.38	8
9	Activity Director	2,093	2,243	21,706	9.68	9
10	Activity Assistants	5,803	6,151	38,254	6.22	10
11	Social Service Workers	5,900	6,254	53,678	8.58	11
12	Dietician					12
13	Food Service Supervisor	2,123	2,080	21,116	10.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,581	26,056	168,006	6.45	15
16	Dishwashers					16
17	Maintenance Workers	6,440	6,826	50,042	7.33	17
18	Housekeepers	31,222	33,095	198,545	6.00	18
19	Laundry	13,657	14,477	89,293	6.17	19
20	Administrator	3,284	2,964	139,783	47.16	20
21	Assistant Administrator					21
22	Other Administrative	6,722	6,722	101,037	15.03	22
23	Office Manager					23
24	Clerical	15,209	16,121	144,001	8.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) QA, Care Plans	6,368	6,750	109,780	16.26	33
34	TOTAL (lines 1 - 33)	259,138	272,453	$ 2,623,390 *	$ 9.63	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	407	$ 10,576	1-3	35
36	Medical Director	140	17,800	9-3	36
37	Medical Records Consultant	96	3,360	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	100	960	10-3	39
40	Physical Therapy Consultant	2,088	100,925	10a-3	40
41	Occupational Therapy Consultant	727	39,315	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	92	6,557	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	165	9,609	12-3	45
46	Other(specify) QI	5	500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,820	$ 189,602		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	934	26,956	10-3	51
52	Nurse Aides	13,243	218,410	10-3	52
53	TOTAL (lines 50 - 52)	14,177	$ 245,366		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debbie Cutright	Administrator	0	$ 58,881
Steve Wolf	Executive Administrator	30	80,902
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 139,783

B. Administrative - Other

Description	Amount
Home Office Prorate	$ 75,455
TOTAL (agree to Schedule V, line 17, col. 3)	$ 75,455
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane, Morris & Hecksher	Legal	$ 8,339
Flynn & Guymon	Legal	904
Van Ostrand	Legal	274
Wessel & Pautsch	Legal	253
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,770

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,550
Unemployment Compensation Insurance	28,806
FICA Taxes	186,872
Employee Health Insurance	62,528
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	16,714
Home Office Proration	20,370
TOTAL (agree to Schedule V, line 22, col.8)	$ 367,840

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 300
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 117)	1,404
Illinois Healthcare Association	5,529
Advertising & Public Relations	35,733
Subscriptions & Publications	2,903
License & Other Dues	1,090
City License	120
Home Office Proration	543
Less: Public Relations Expense	(20,791)
Non-allowable advertising	(627)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,204

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Home Office Proration	230
In-State Travel	
Mileage	74
Seminar Expense	9,448
Home Office Proration	2,508
Out of State Travel	(230)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,030

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	Not Applicable												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eldercare of Alton **#** 0023317 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Assoc. $5,529**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,500** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **102,664**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation. Costs for St Louis within 50 miles
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.